CLAIM VERIFICATION SYSTEM

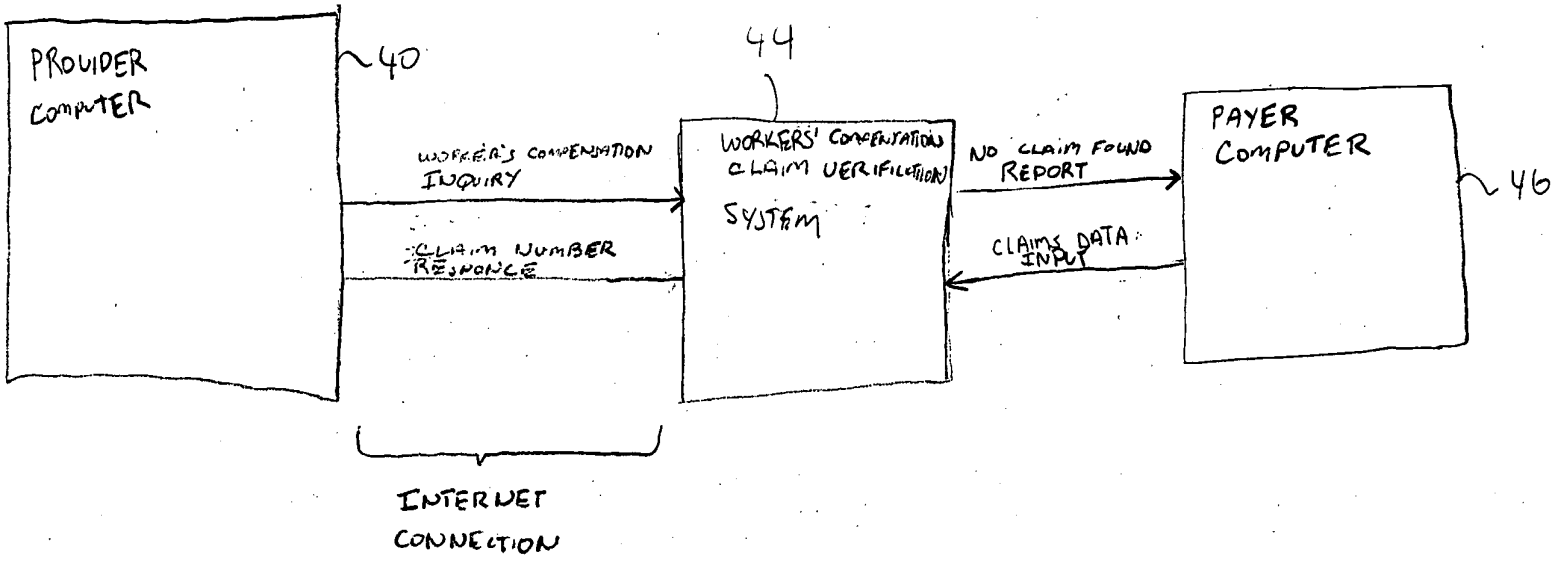
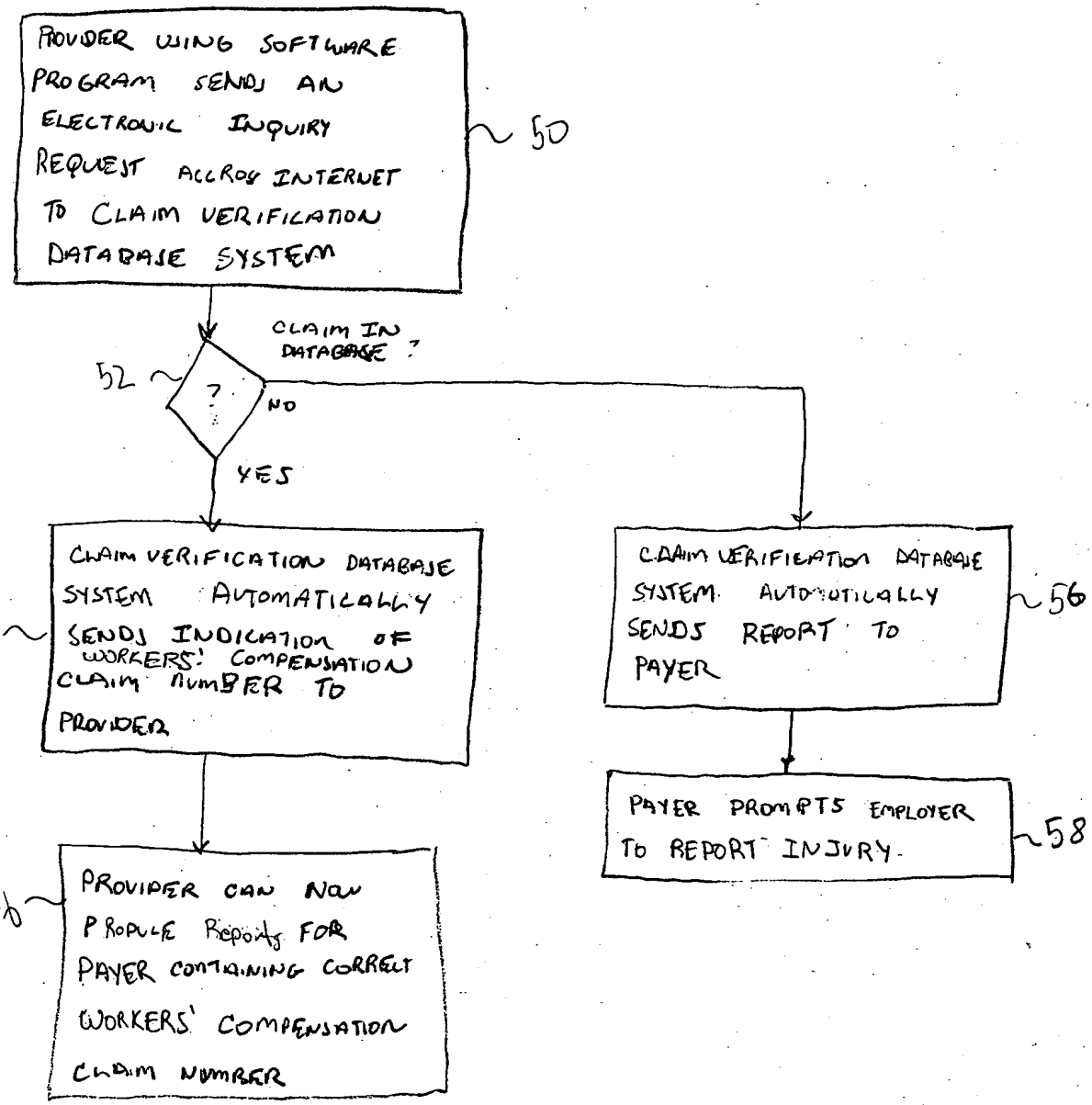


FIGURE 1



SCANNED 7

FIGURE 2

WORKER'S COMPENSATION
MEDICAL TREATMENT REPORTING

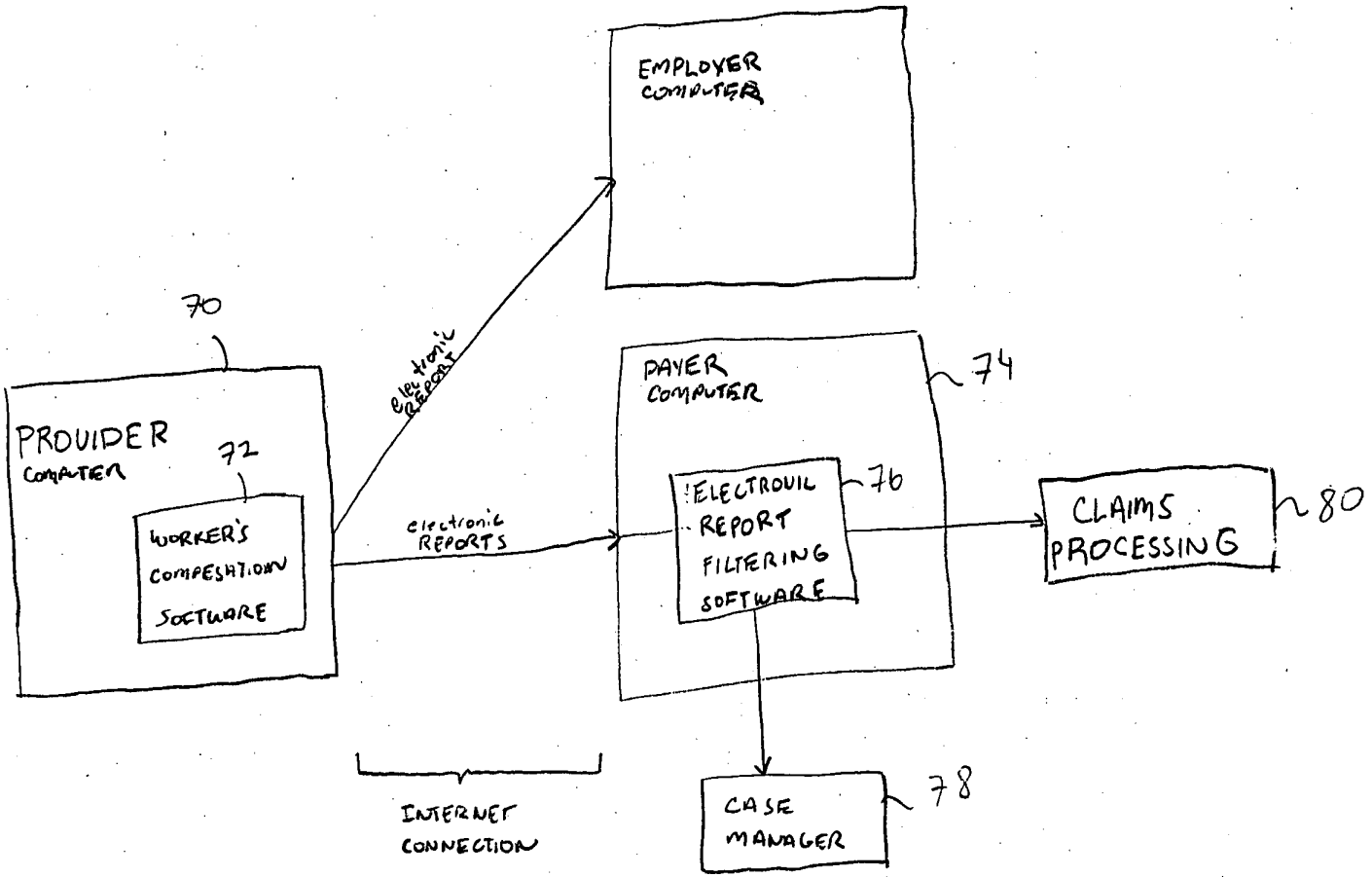


FIGURE 3

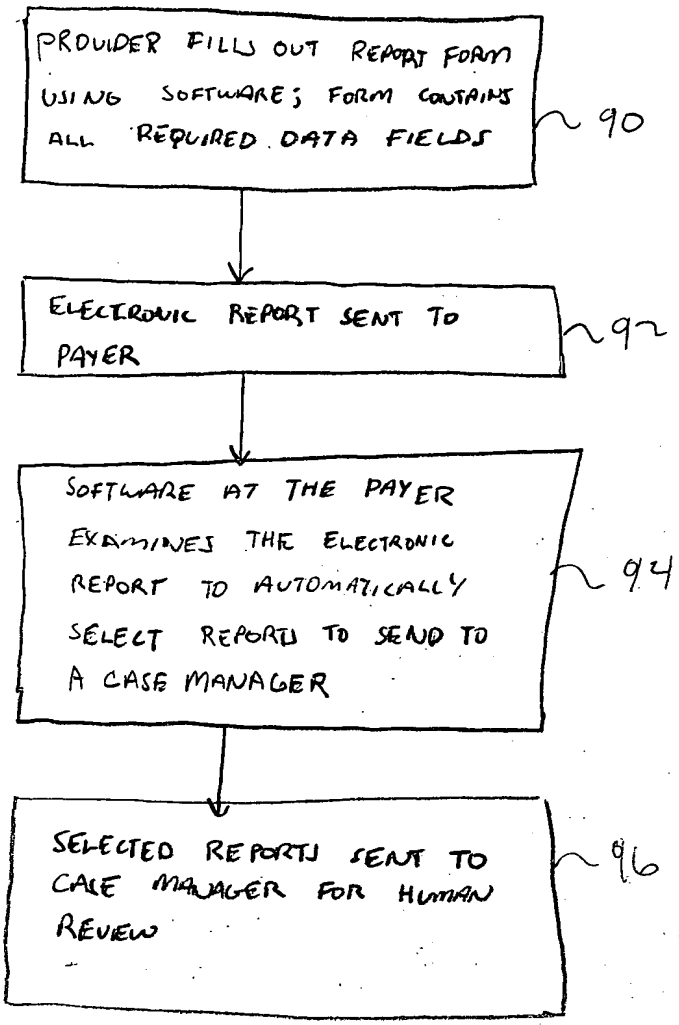


FIGURE 4

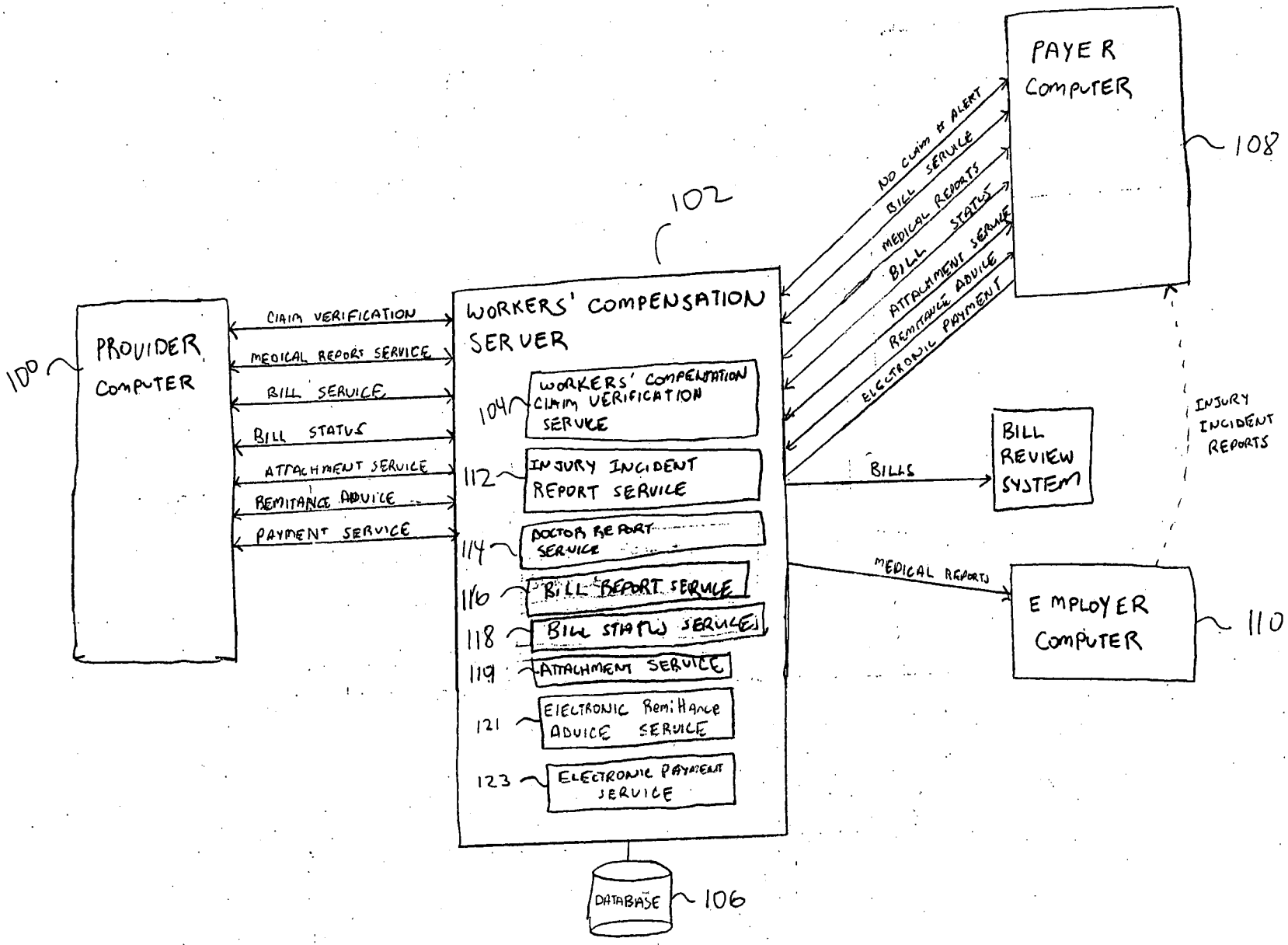

PROVIDER COMPUTER
100
CLAIM VERIFICATION
MEDICAL REPORT SERVICE
BILL SERVICE
BILL STATUS
ATTACHMENT SERVICE
REMITANCE ADVICE
PAYMENT SERVICE
WORKERS' COMPENSATION SERVER
102
104 WORKERS' COMPENTATION CLAIM VERIFICATION SERVICE
112 INJURY INCIDENT REPORT SERVICE
114 DOCTOR REPORT SERVICE
116 BILL REPORT SERVICE
118 BILL STATUS SERVICE
119 ATTACHMENT SERVICE
121 ELECTRONIC REMITANCE ADVICE SERVICE
123 ELECTRONIC PAYMENT SERVICE
DATABASE
106
NO CLAIM IS ALERT
BILL SERVICE
MEDICAL REPORTS
BILL STATUS
ATTACHMENT SERVICE
REMITANCE ADVICE
ELECTRONIC PAYMENT
PAYER COMPUTER
108
BILLS
BILL REVIEW SYSTEM
INJURY INCIDENT REPORTS
MEDICAL REPORTS
EMPLOYER COMPUTER
110

FIGURE 5

First Report (Input Form)

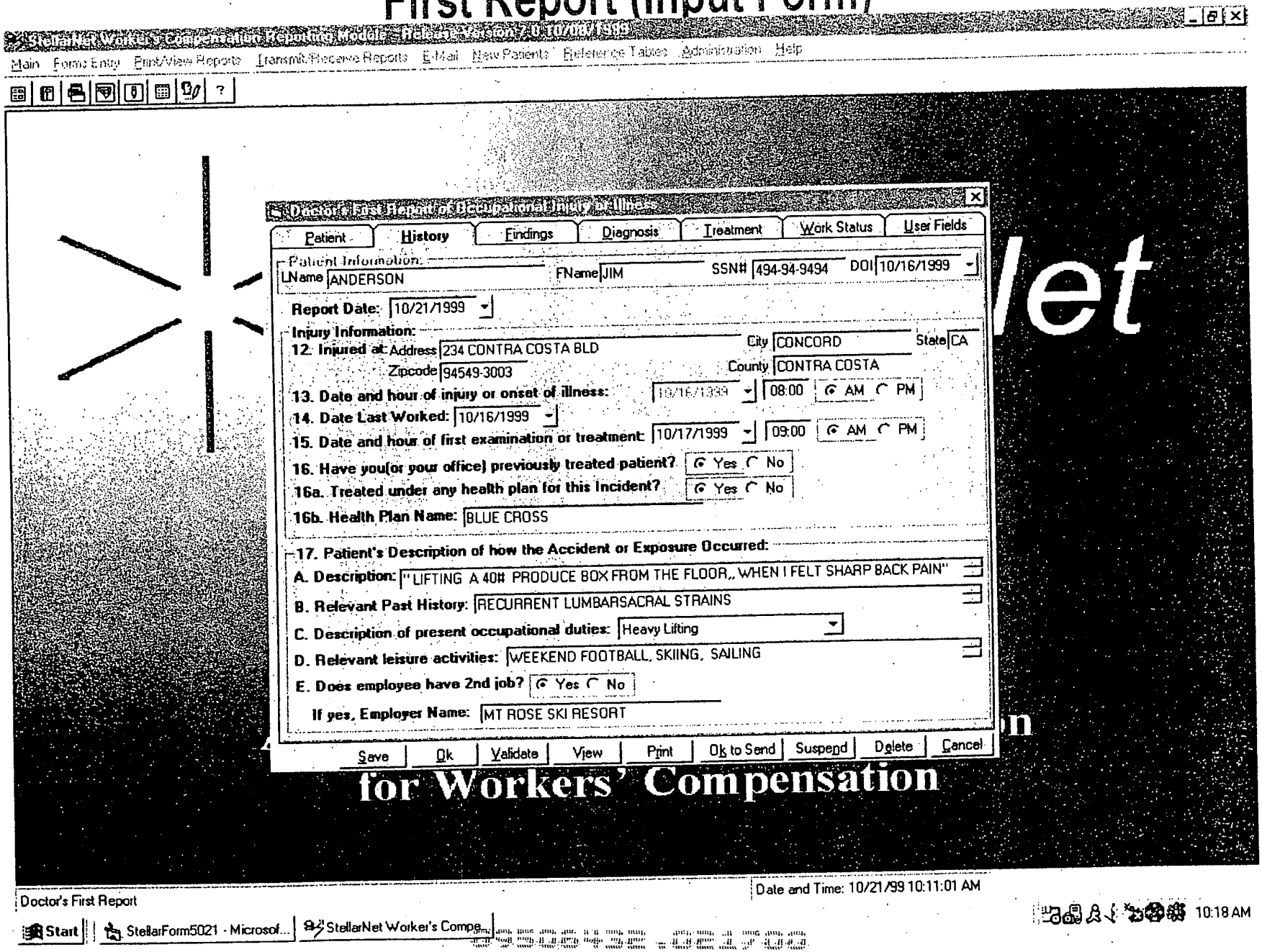


FIGURE 6

Report Page 1

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Page 1 of 2

STATE OF CALIFORNIA
Form SHIEL @1999

File Copy
FROM: FIRST CARE

Form ID: INS000001000000002

1. INSURER NAME AND ADDRESS
ZENITH, 123 COAST DRIVE, SAN FRANCISCO, CA 945493393
Telephone Number: 415-939-3939 Fax Number: 415-339-3939

1b. Claim #

REPORT DATE
10/17/1999

2. EMPLOYER NAME	3. Address No and Street	City	State	Zip	Telephone #
LUCKY STORES	234 MARINA WAY	SAN LEANDRO	CA	945493993	510-499-4949

4. Nature of Business: GROCERY STORE Policy Number: 499-49-4994 Fax Number: 510-393-9393

5. PATIENT NAME (first name, middle initial, last name)	6. Sex	7. Date of Birth	Mo	Day	Year
JIM ANDERSON	☑ Male ☐ Female		10	14	1949

8. Address	City	State	Zip	9. Home Tel #	Work Tel #
1744 RELIEZ VALLEY RD	LAFAYETTE	CA	945498888	925-838-3838	925-884-8484

10. Occupation (Specific job title)	11a. Social Security #	11b. Date of Hire:	11c. Patient Account#:
JOURNEYMAN CLERK	494-94-9494	10/23/1994	848484848484

12. Injured At	City	State	Zip	County
234 CONTRA COSTA BLD	CONCORD	CA	945493003	CONTRA COSTA

13. Date and hour of injury or onset of illness:	Mo	Day	Year	Hour		14. Date Last Worked:	Mo	Day	Year
	10	16	1999	08:00	AM		10	16	1999

15. Date and hour of first examination or treatment:	Mo	Day	Year	Hour		16. Have you (or your office) Previously Treated Patient? ☑ Yes ☐ No
	10	17	1999	09:00	AM	

16a. Treated under any Health Plan for this Incident? ☑ Yes ☐ No 16b. Health Plan Name: BLUE CROSS

17. PATIENT'S DESCRIPTION OF HOW THE ACCIDENT OR EXPOSURE OCCURRED:

A. Description: " LIFTING A 40# PRODUCE BOX FROM THE FLOOR, WHEN I FELT SHARP BACK PAIN"

B. Relevant Past History: RECURRENT LUMBARSACRAL STRAINS

C. Description of Present Occupational Duties:
Heavy Lifting

D. Relevant leisure Activities: WEEKEND FOOTBALL, SKIING, SAILING

E. Does Employee have 2nd job? ☑ Yes ☐ No If yes, Employer Name: MT ROSE SKI RESORT

18. SUBJECTIVE COMPLAINTS:

A. Description: SHARP LOW BACK PAIN

B. Symptoms:

Body Part	Onset	Quality	Frequency	Severity	Precipitating Activities
Lower Back	Sudden	Sharp;	Constant	Moderate	Lifting;Bending;Sitting;

19. OBJECTIVE FINDINGS:

A. Vital Signs:
BP: 120/80 HT: 5'8 WT: 190 Pulse: 78 Temp: 98.6 Resp: 18 /min

Allergic to any medications? ☐ Yes ☑ No If yes, specify:

B. Focused Physical Exam:
45 DEGREES LUMBAR FLEXION WITH POSITIVE RIGHT STRAIGHT LEG RAISE AT 60 DEGREES

C. X-Ray and Laboratory Results:
NONE

D. Job Description Reviewed: ☐ Yes ☑ No

20. DIAGNOSIS: (If occupational illness, specify etiologic agent and duration of exposure)

A. Description: SPRAIN LUMBOSACRAL

B. ICD9 Codes: 8460

C. Chemical Or Toxic Compounds Involved? ☐ Yes ☑ No
If yes, explain:

D. Other Relevant Diagnosis

21. ARE FINDINGS AND DIAGNOSIS CONSISTENT WITH PATIENT'S ACCOUNT OF INJURY OR ONSET OF ILLNESS? ☑ Yes ☐ No
If no, explain:

A. Did work cause or contribute to the injury or illness? ☑ Yes ☐ No ☐ Cannot determine
If no or cannot determine, explain :

FIGURE 7A

Report Page 2

--- CONTINUED DOCTOR'S FIRST REPORT OF INJURY ---ANDERSON,JIM 494-94-9494

B. Is the patient permanent and stationary? ☐ Yes ☑ No If yes, Date :

C. If no, estimated permanent and stationary date : 11/05/1999

D. Is permanent disability anticipated ? ☐ Yes ☑ No

22. IS THERE ANY OTHER CURRENT CONDITION THAT WILL DELAY PATIENT'S RECOVERY? ☑ Yes ☐ No

If yes, explain: Prior injury to same body part

23. TREATMENT RENDERED:

A. First Aid : ☐ Yes ☑ No

B. Treatment Date: 10/17/1999 Treatment: OFFICE/OUTPATIENT VISIT, EST

C. Procedure Codes: 99212

D. Instructions to Patient: ERGONOMIC EDUCATION , HEAT AND LOW BACK EXERCISES

E. Referrals:

F. Disability status: Discharged as cured, with no need for further medical care? ☐ Yes ☑ No

G. If discharged, Discharge Date:

24. IS FURTHER TREATMENT REQUIRED? ☑ Yes ☐ No

A. Medication: VICODIN

B. Physical Therapy: 2 per week for 3 weeks

C. If Surgery, type:

CPT Code:

D. Diagnostic Tests:

E. Estimated Duration of Treatment: 25 days

F. Return Visit Interval: ONE WEEK

G. Recommended Referrals:

H. Treatment Plan, Other:

25. IF HOSPITALIZED AS INPATIENT, Give Hospital Name and Location: Date Adm: Mo Day Yr Est. Stay: Days

26. WORK STATUS:

A. Is Patient able to Perform Usual Work? ☐ Yes ☑ No

B. If not, date when patient can return to, Regular Work: 10/26/1999

C. If not, date when patient can return to Modified/Transitional work: 10/20/1999

D. Restrictions: Specific functional limitations/frequency and weight restrictions based on an 8 hour work day:

Key: (U)nable, (S)eldom =<1%, (O)ccasional 1-33%, (F)requent =34%-66%, (C)ontinuous =67%-100%

Activity	Limitation	Weight Limit:
Repetitive Bending	Seldom =< 1%	
Lifting From Floor	Unable	
Lifting From Waist	Occasional 1-33%	MAX 15#

E. Restrictions Narrative:

F. Is employee likely to become a Qualified Injured Worker? ☐ Yes ☑ No

27. Doctor's Name and Degree: CLIFF L WILSON,MD

Facility Name: FIRST CARE

Address: 123 TAYLOR ST , LAFAYETTE , CA 945498880

PPO Network:

IRS #: 393934481

CA License #: CA2338193488

Speciality: OCC MED

Doctor's Telephone #: 925-384-8505

<<<DOCTOR'S SIGNATURE ON FILE AT DOCTOR'S OFFICE>>>

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying worker's compensation benefits or payments is guilty of a felony.

Figure 73

Input Form

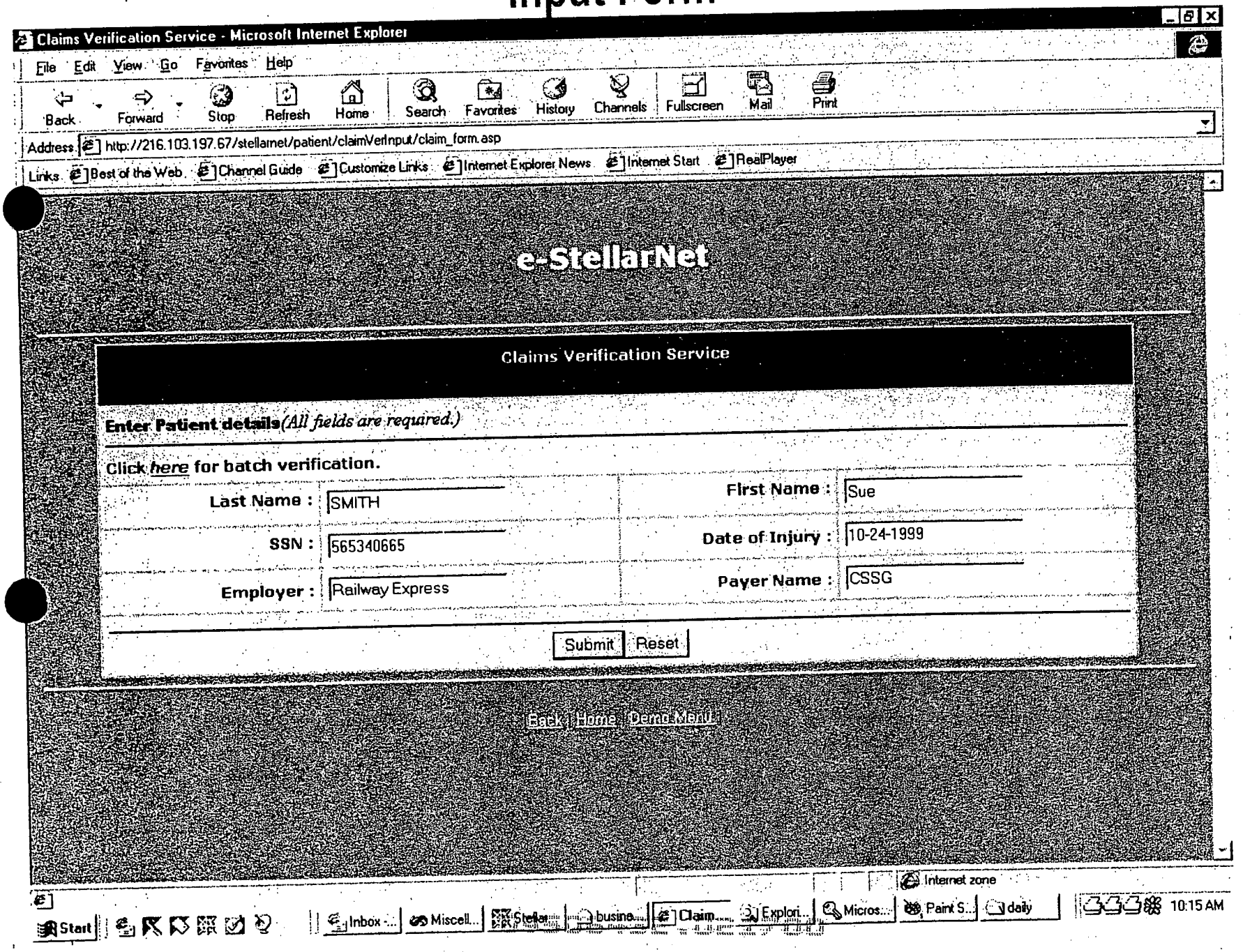


FIGURE 8A

Result Page

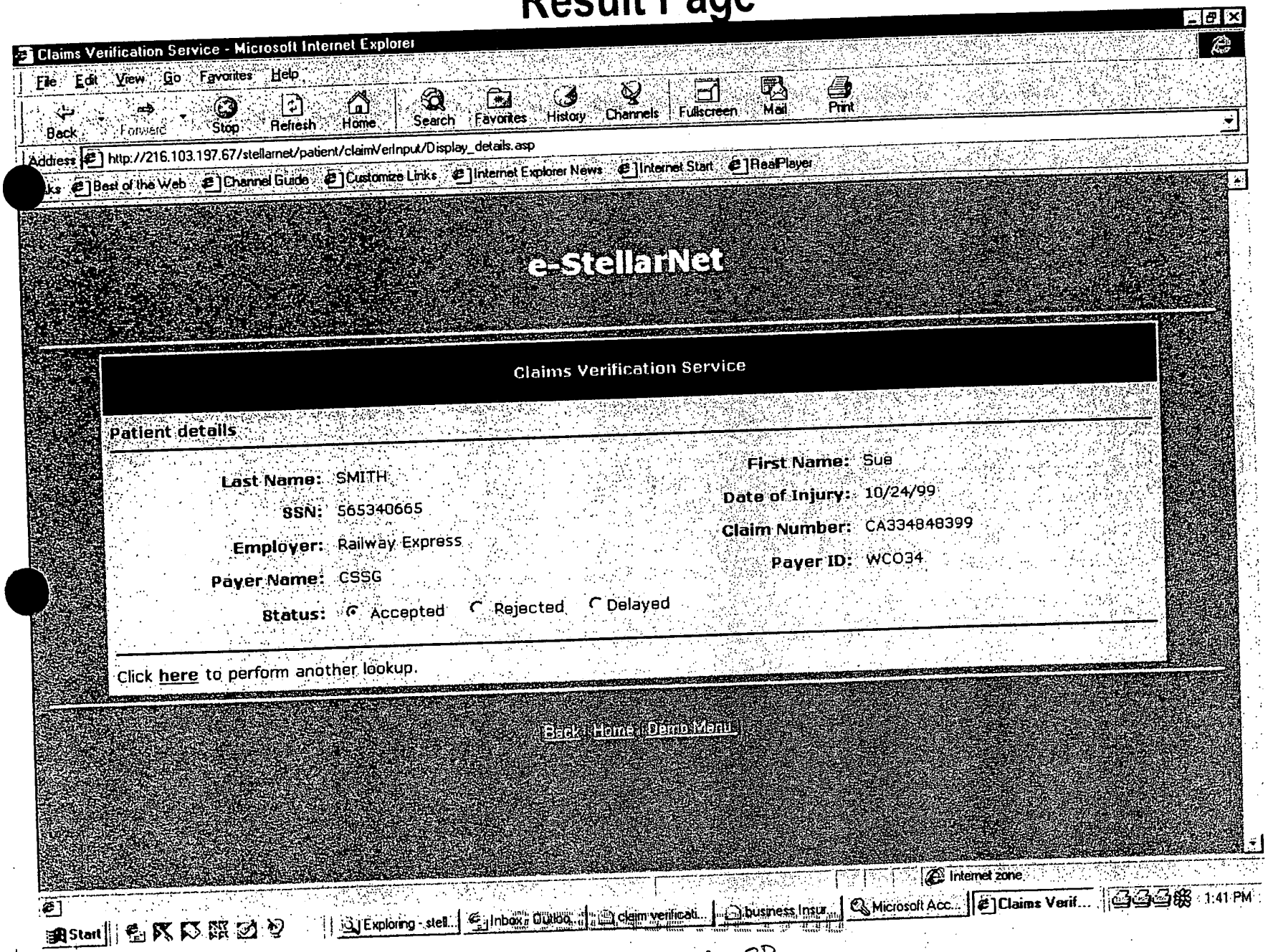


FIGURE 8B

Alert Email

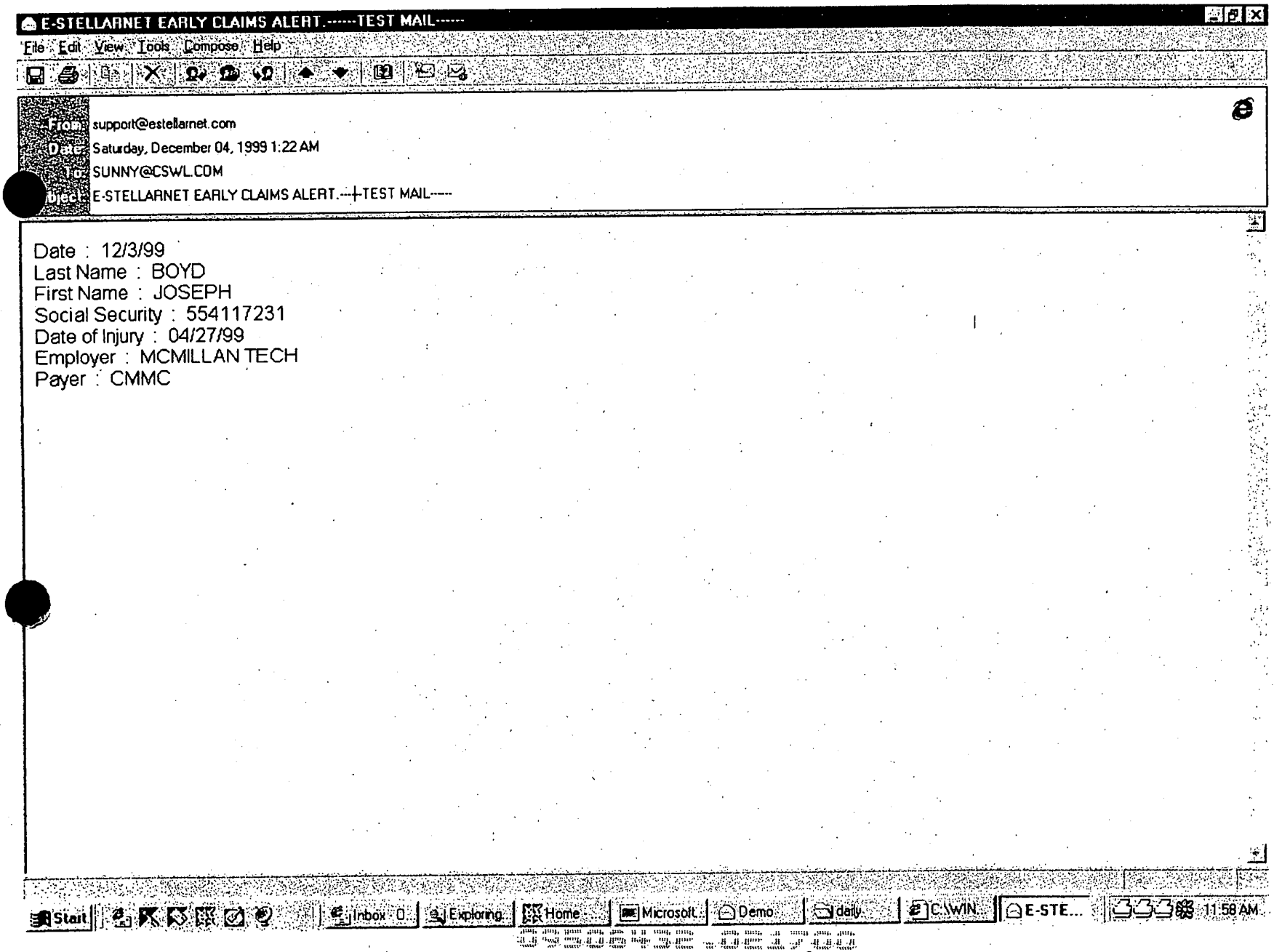


FIGURE 8C

Inquiry Email (Form)

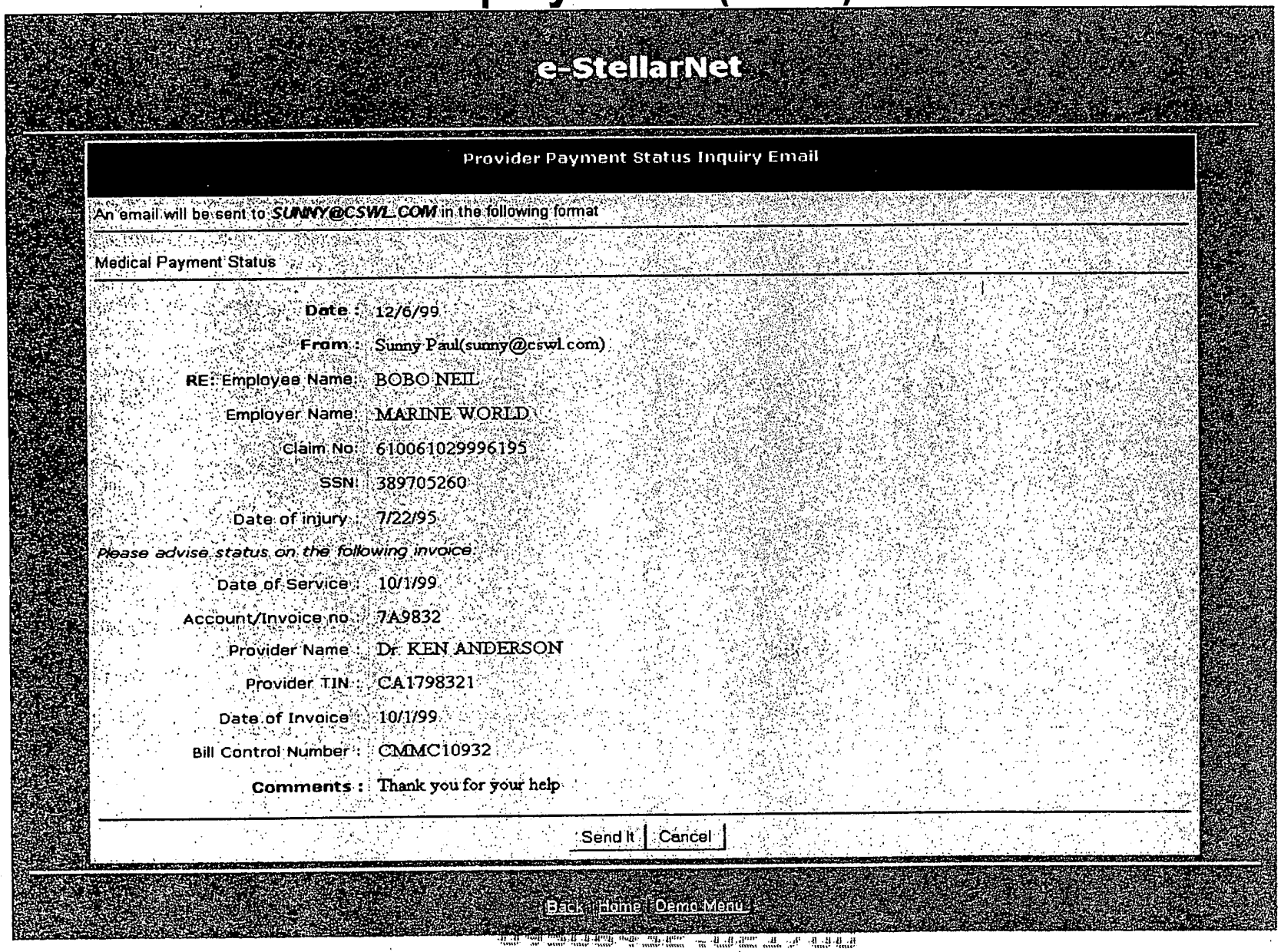


FIGURE 9A

Received Email

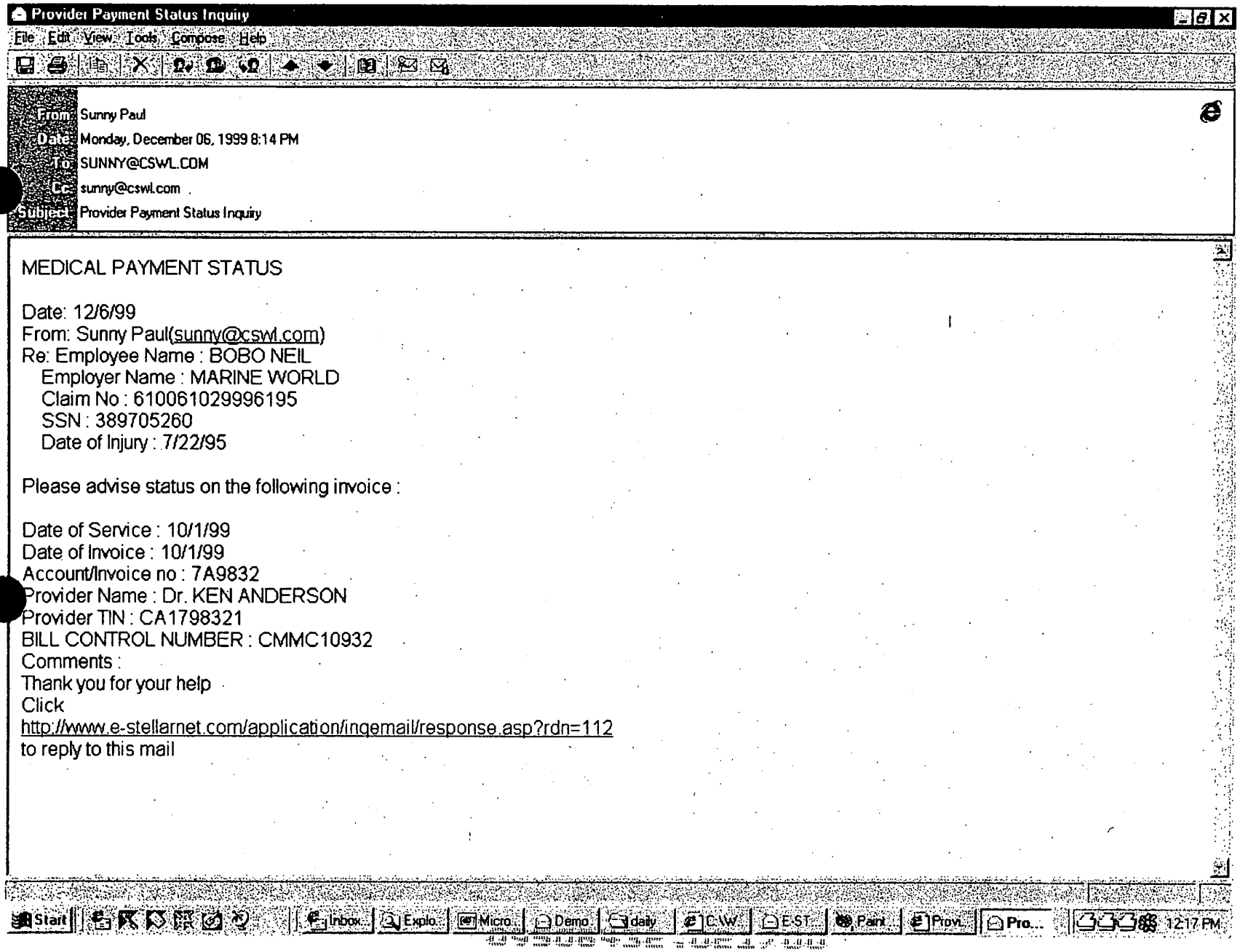


FIGURE 9B

Response Form

e-StellarNet

Provider Payment Status Inquiry - Response Email form

To Medical Facility : *sunny@cswl.com*

Bill Control No.(BCN) : CMMC10932 *(For future reference please use the above BCN)*

The status of above Invoice is:

- (•) Our records indicate payment was released on 10/28/1999
- ( ) Our records indicate payment was paid in accordance with our contract agreement.
- ( ) No further payments are recommended
- ( ) Claim is currently under review for medical necessity
- ( ) Claim is currently under **AOE/COE** investigation.
- ( ) Claim was denied
- ( ) Necessity for this service is currently under review.
- ( ) No Policyholder Under This Name.
- ( ) We do not have coverage for this employer for this Date of Injury.
- ( ) No Industrial Injury Reported By Employer.
- ( ) Doctor's First Report Needed.
- ( ) Current Medical Report Needed.
- ( ) Itemized Statement Needed.
- ( ) Other

Next Page | Reset

[Back] [Home] [Main Menu]

FIGURE 9C

Response Email

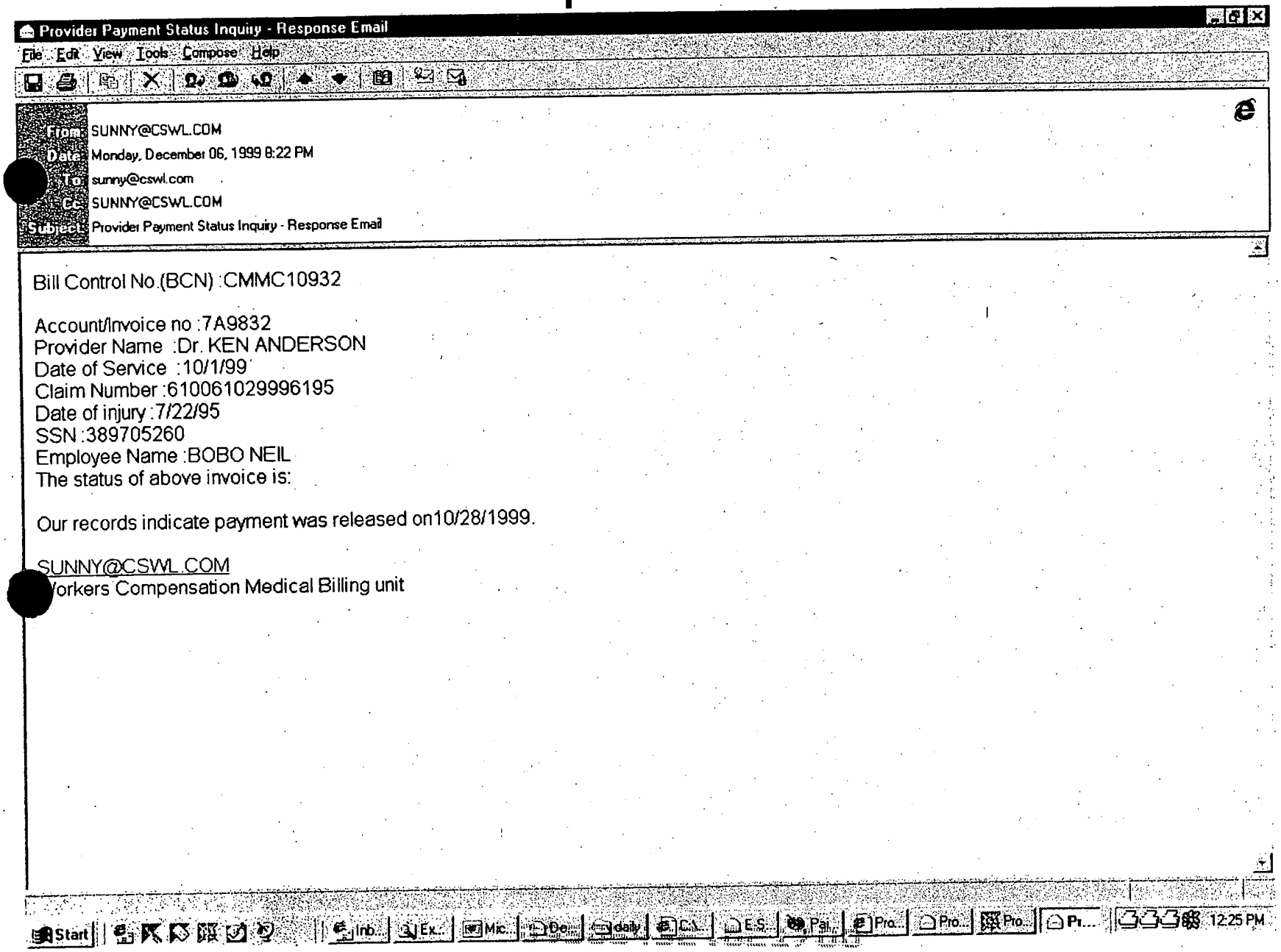


FIGURE 9D

Stellar Net Home Page

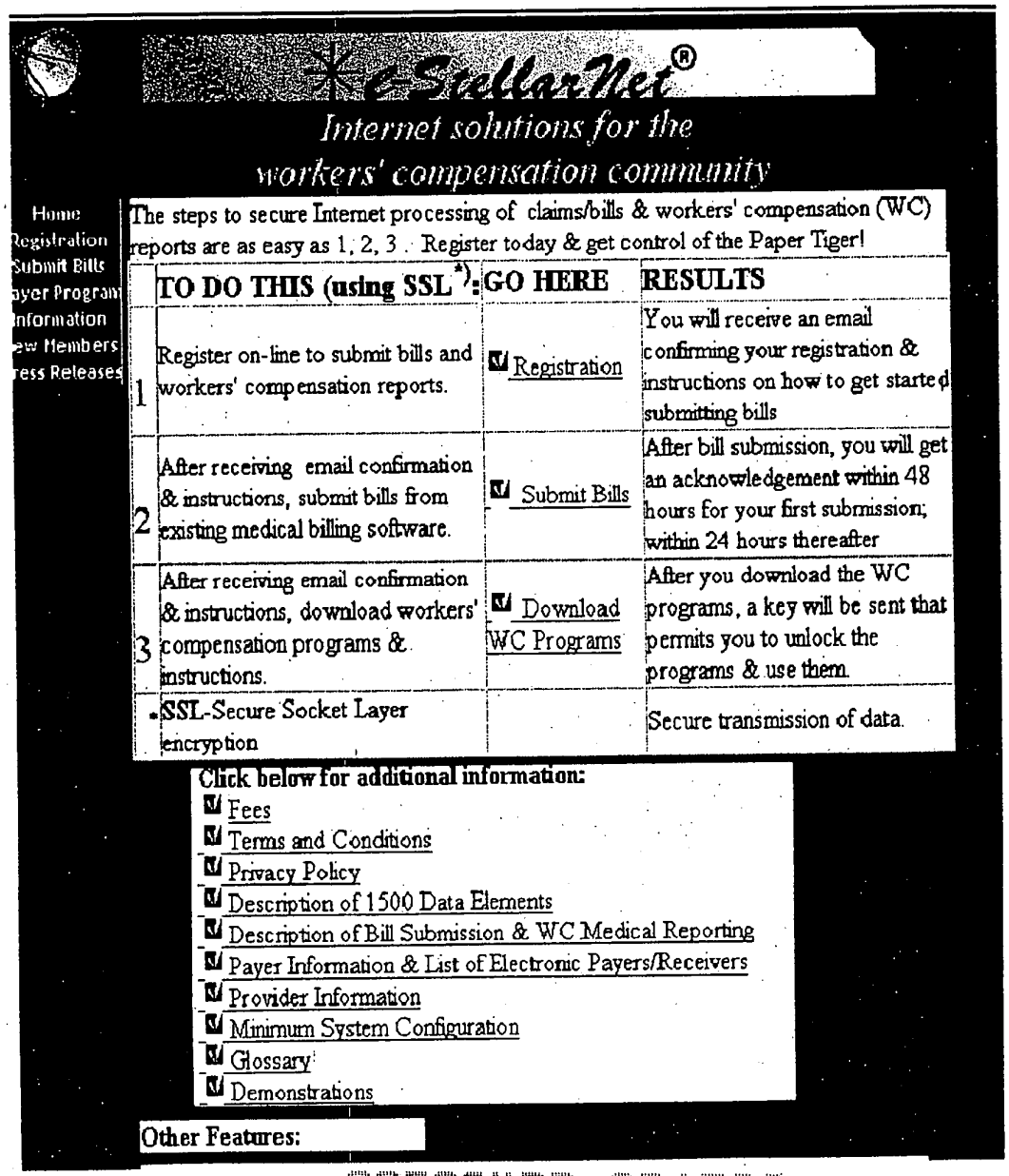


FIGURE 10A

StellarNet On-Line Bill Submission Form

e-Stellar*Net*® On-Line Bill Submission

Welcome to StellarNet's on-line bill submission page. Please complete the form:

1. If you are not registered, click here to go to registration page.

2. Registered members, proceed with bill submission:

a. Input your email address in the first box and click on "Report" to double check your membership status. If you are not registered, or if the email address is incorrect, you will get an error message.

b. To submit your bills use the "Browse..." button to select the name and location of the file(s) to submit. You can submit up to 3 files at one time.

c. To submit the bills, click "Upload file(s)!" to submit bills

If you are a first time submitter, you will receive an acknowledgement back within 48 hours after you have submitted your first batch of bills. Thereafter, you will receive the acknowledgement back within 24 hours of submitting your bills.

Please press the TAB key **NOT** the ENTER key to move down. Use Shift TAB to move up.

Member Upload Password or Email: [ ] Report

Files To Upload:

File 1: [ ] Browse...

File 2: [ ] Browse...

File 3: [ ] Browse...

Upload File(s)! Reset Form

Use browser's BACK button to return to previous page.

If you have any questions...

Call us at 415/882-5700, or Email us at rtwfast@ibm.net

FIGURE 10B

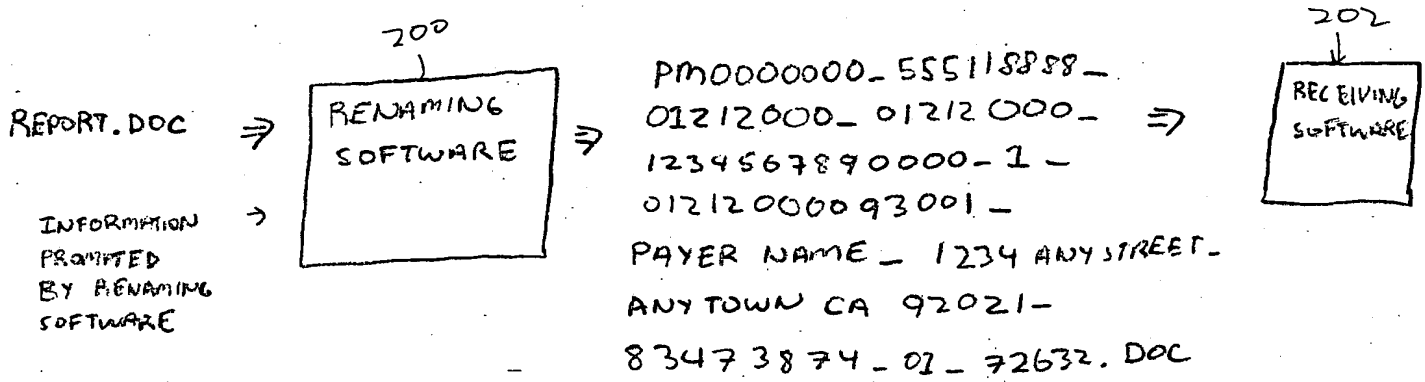


FIGURE 11

Field Name	Len	Type	Description / Example
Payer ID	9	Char	Electronic payer ID example: WACA02012. Print and mail payer ID is always PM0000000.
Patient's SSN	9	Char	Example: 123880000
Date of Injury	8	Char	MMDDYYYY Jan 20, 2000 example: 01202000
Date of Service	8	Char	MMDDYYYY Jan 21, 2000 example: 01212000
Type of Service	1	Char	1=Medical Care, 2=Surgery, 3=Consultation, 4=Diagnostic X-ray, 5= Diagnostic Laboratory, 6=Radiation Therapy, 7=Anesthesia, 8=Assistance at Surgery, 9=Other Medical Service, 0=Blood or Packed Red Cells, A=Used DME, F=Ambulatory Surgical Center, H=Hospice, L=Renal Supplies in the Home, M=Alternate Payment for Maintenance Dialysis, N=Kidney Donor, V=Pneumococcal Vaccine, Y=Second Opinion on Elective Surgery, Z=Third Opinion on Elective Surgery.
Provider Tax ID + Sub ID	13	Char	1234567890000 (use 0000 if not using sub ID)
Submit Date and Time	12	Char	MMDDCCYYHHMMSS Jan 22, 2000 9:30 01 am example: 01222000093001
Payer Name	25	Char	ABC WC PAYER
Payer Address	25	Char	100 MAIN STREET
Payer City State Zip	25	Char	BIG CITY NY 00030
Claim Number	28	Char	20303200223
Type of Document	2	Char	01=First Report, 02=Supplemental Report, 03=P&S Report, 04=QME, 05=Consult, 06=AME, 07=Entire File, 08=Diagnostic, 09=Chart Notes, 10=Pre-Authorization Request, 11=Referral Request, 12=Disability Status, 13=Surgical, 14=Ambulance, 15=Ancillary, 16=Home Care, 17=Other
ICD9	6	Char	Primary Diagnosis Code, no spaces no period on 5 digit codes.
Period	1	Char	. (also known as dot)
File Type	3	Char	Original file extension, DOC, RTF, TXT, etc.

FIGURE 12

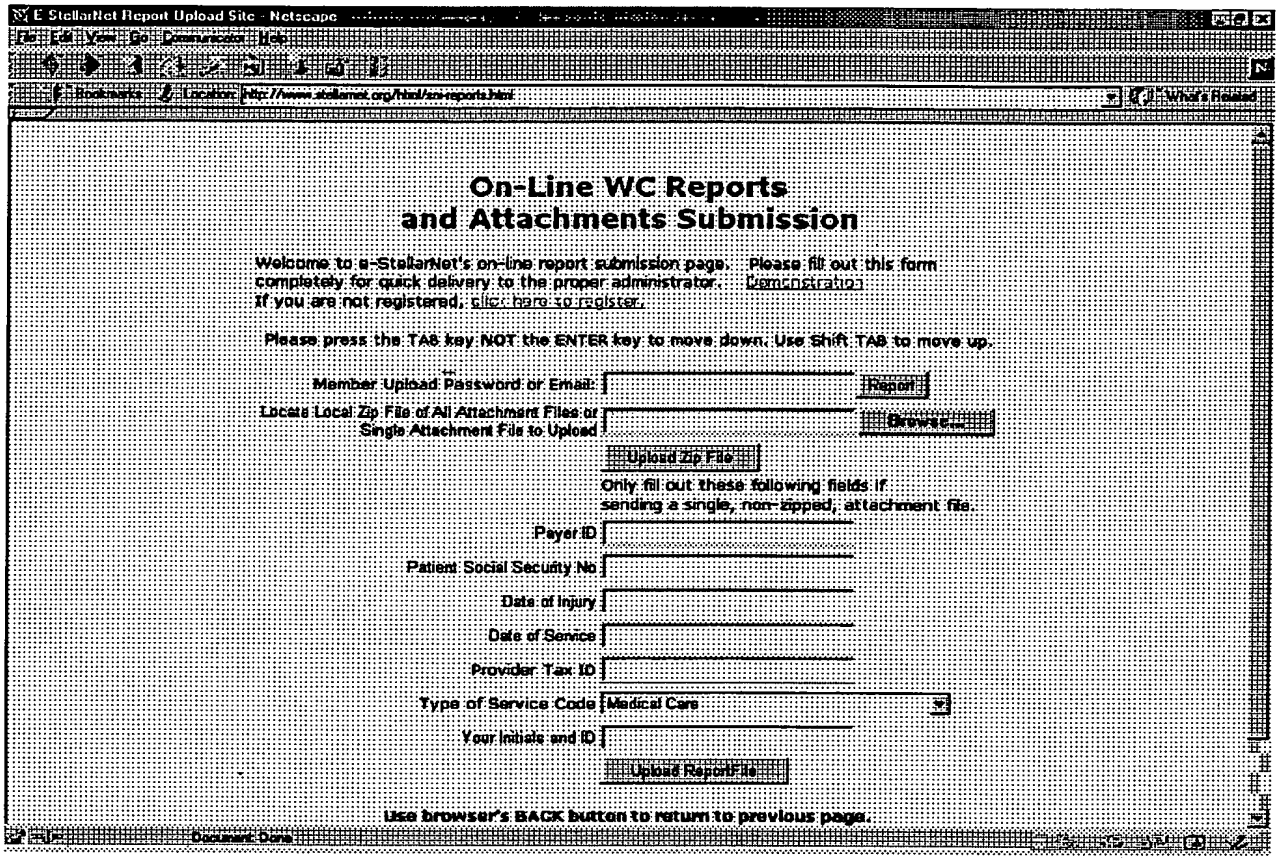

E StellarNet Report Upload Site - Netscape
File Edit View Go Communicator Help
Bookmarks Location: http://www.stellarnet.org/html/on-reports.html
What's Related
On-Line WC Reports
and Attachments Submission
Welcome to e-StellarNet's on-line report submission page. Please fill out this form completely for quick delivery to the proper administrator. Demonstration
If you are not registered, click here to register.
Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.
Member Upload Password or Email:
Report
Locate Local Zip File of All Attachment Files or Single Attachment File to Upload
Browse...
Upload Zip File
Only fill out these following fields if sending a single, non-zipped, attachment file.
Payer ID
Patient Social Security No
Date of Injury
Date of Service
Provider Tax ID
Type of Service Code
Medical Care
Your Initials and ID
Upload Report File
Use browser's BACK button to return to previous page.
Document Done

FIGURE 13